

State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)

**FORENSIC MEDICAL REPORT: ACUTE
CHILD/ADOLESCENT SEXUAL ABUSE
EVIDENTIARY EXAMINATION**

**ADOLESCENTS AGES 12-17 < 120 HOURS
CHILDREN UNDER 12: FOLLOW
LOCAL SART GUIDELINES**

INSTRUCTIONS

CAL OES 2-930

July 2020



For copies of this form or assistance in completing
the Cal OES 2-930, please contact

California Clinical Forensic Medical Training Center
www.ccfmtc.org

Cal OES 2-930 INSTRUCTIONS

Forensic Medical Report: Acute Sexual Abuse Evidentiary Examination

Adolescents Ages 12–17 (< 120 Hours) & Children Under Age 12 (Follow Local SART Guidelines)

REQUIRED USE OF STANDARD FORM

Penal Code section 13823.5(c) requires that every health care practitioner who conducts a medical examination of a sexual assault or child sexual abuse victim for evidence of sexual assault or abuse use a standard form to record findings. This form is intended to document medical/evidentiary examination findings and, as such, is not a complete medical treatment record.

USE OF THE STANDARD STATE FORMS: FOLLOW SEXUAL ASSAULT RESPONSE TEAM (SART) GUIDELINES.

Cal OES 2-923	<ul style="list-style-type: none"> History of acute sexual assault (< 120 hours) Examination of adults (age 18 and over) and adolescents (ages 12–17) 	Key Terms for Sexual Assault or Sexual Abuse Exams	
Cal OES 2-925	<ul style="list-style-type: none"> History of nonacute sexual abuse: Follow local SART guidelines due to jurisdictional variations Examination of children and adolescents under age 18 	Acute	Less than 120 hours have passed since the incident (< 120 hours)
Cal OES 2-930	<ul style="list-style-type: none"> History of acute sexual abuse or sexual assault Examination of adolescents ages 12-17 (< 120 hours) Examination of children under age 12: Follow local SART guidelines due to jurisdictional variations 	Nonacute	More than 120 hours have passed since the incident (> 120 hours)
Cal OES 2-930	<ul style="list-style-type: none"> History of chronic sexual abuse (incest) and recent incident Examination of adolescents ages 12-17 (< 120 hours) Children under age 12: Follow local SART guidelines due to jurisdictional variations 		
Cal OES 2-950	<ul style="list-style-type: none"> Examination of person(s) suspected of sexual assault or sexual abuse 		

INSTRUCTIONS FOR Cal OES 2-930: These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code section 13823.11 for performing medical evidentiary examinations. These terms are used to describe time frames, not rigid standards. This is not to suggest that after 120 hours a complete exam should not be done. It is not unusual to detect injuries or possible trace and biological evidence after 120 hours. For infants, young children, and adolescents, there are many variables to consider. Use clinical judgment and/or follow local SART guidelines.

LIABILITY AND RELEASE OF INFORMATION: This medical evidentiary exam report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Pen. Code § 11164 or privilege), the Medical Information Act (Civ. Code § 56 et seq.), the Physician-Patient Privilege (Evid. Code § 990), and the Official Information Privilege (Evid. Code § 1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, a child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient Identification: This space is provided for hospitals and clinics using labels or plastic plates for stamping identification information.
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A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

- Enter the patient's name and identification number (if applicable); Enter date/time of arrival; and date/time of discharge.
- Enter the patient's age, date of birth (DOB), biological gender, identified gender, preferred pronouns, and ethnicity.
- Enter the patient's address, city, county, state, and telephone number.
- Enter the name of parent, stepparent, guardian, address, city, county, state, and telephone numbers.
- Enter the name of parent, stepparent, guardian, address, city, county, state, and telephone numbers.
- Enter the name(s) of siblings, gender, age, and date of birth (DOB).

B. REPORTING AND AUTHORIZATION: Indicate jurisdiction where the incident(s) occurred. Penal Code section 11166 requires all professional medical personnel to report suspected child abuse, defined by Penal Code section 11166, immediately by telephone and to submit a written report (DOJ SS 8572 also called the 11166) within 36 hours to the local law enforcement or Child Protective Services.

- Check the appropriate box to indicate whether a telephone report was made to a law enforcement agency and/or to Child Protective Services. Identify the person who took the report by name, agency, identification number, and telephone number.
- If the patient was accompanied to the medical facility by law enforcement or Child Protective Services, enter the person's name and identifying information.
- If known, identify the law enforcement and/or Child Protective Services investigator assigned to this case.
- Obtain the name of a law enforcement and/or Child Protective Services investigator to authorize payment for the evidentiary exam at public expense, the name of the agency, telephone number, date, time, and case number. If telephone authorization was obtained, enter the name of the authorizing party, identification number, and the date and time in the Telephone Authorization box.

Note: Medical facilities with contracts or memorandums of understanding may not require individual patient authorizations.

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN

- Parental consent is not required for suspected sexual abuse examinations. Some jurisdictions require warrants for exigent and non-exigent circumstances.
- Family Code section 6927 permits minors (12–17 years of age) to consent to medical examination, treatment, and evidence collection related to a sexual assault without parental consent. Family Code section 6928 requires health care professionals to attempt to contact the minor's parent or legal guardian, and to note in the minor's treatment record the date and time the attempted contact was made, including whether the attempt was successful or unsuccessful. This provision is not applicable when the health professional reasonably believes the parent(s) or guardian committed the sexual assault on the minor.

D. PATIENT HISTORY

1. **Record the time or time frame of the incident(s) and date(s).**
 - For children, use familiar dates and time frames (holidays, birthdays, weekday or weekend, nighttime, or daytime).
 - Check the box if there were multiple incidents over time.
2. **Describe the location of the most recent incident(s).**
 - During the physical examination, look for pattern injuries associated with the physical surroundings (e.g., fibers, grass, sand) transferred from the scene to the patient.
3. **Record the terms the patient uses for the female and male genitalia, breasts, and anus.**
4. **Record the identity of the alleged perpetrator(s) by name or nickname, approximate age, gender, ethnicity, relationship to the patient, and whether the perpetrator(s) are known or unknown to the patient.**
 - Use a numbering system to identify multiple perpetrators by name, if known, or a brief description such as the "big guy." This numbering system can be used to relate the perpetrator to the acts described by the historian and/or patient on pages 3 and 4.

E. MEDICAL HISTORY

1. **Record the name of the person providing the medical history, relationship to the patient, and date and time of examination.**
2. **Any recent (past 60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?**
 - This information is requested to avoid confusing pre-existing lesions with injuries or findings related to the alleged abuse.
3. **Any other pertinent medical conditions that may affect the interpretation or physical findings?**
4. **Any pre-existing physical injuries?**
5. **Any previous history of physical abuse and/or neglect?**
6. **Any previous history of sexual abuse?**
7. **For adolescents, ask whether the patient has had other oral, anal, or vaginal intercourse within the past 5 days. If yes, ask when. If yes, ask whether intravaginal ejaculation occurred and whether a condom was used.**

The information is needed by the examiner to interpret the genital findings. The information is also required by the crime laboratory to properly interpret the findings. **Do not record any other information regarding sexual history on this form.**

8. **Record whether menstrual periods have started, the age of menarche, the date of the last menstrual period, and whether the patient is menstruating at the time of the exam.**
9. **Record other symptoms described by the patient and/or historian. Describe onset, duration, and intensity of symptoms.**
10. **Record post-assault hygiene activity, if the incident occurred within 120 hours of the examination.**
 - This information is relevant because it can affect the interpretation of the findings.
 - If the patient has bathed, showered, or douched, the examiner should still collect samples from the appropriate body areas to attempt to preserve any biological or trace evidence.
 - Ask the patient if tissues, wipes, or clothing were used to cleanse the mouth, genitals, and/or body. If yes, collect these items, if available. Air dry, package, label, and seal. If not available, notify law enforcement so these items may be collected.

F. ACTS DESCRIBED BY HISTORIAN

- Record the name of the historian, his or her relationship to the patient, telephone number, and indicate agency name if law enforcement, Child Protective Services, or a specialized interview center for children served as the historian.
- Record acts described by the historian and any additional pertinent history. Indicate if a question was not asked. For yes answers, ask if there was associated pain or bleeding, and describe in the space provided.

<ul style="list-style-type: none"> Breast/Anal/Genital fondling 	<p>Mark the appropriate box. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.</p>
<ul style="list-style-type: none"> Genital: vulva, vestibule, vagina contact/ penetration Anal contact/penetration 	<p>Mark the appropriate box for each method of contact/penetration. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. If an object was used, describe it.</p>
<ul style="list-style-type: none"> Oral copulation of genitals Oral copulation of anus 	<p>Mark the appropriate box. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.</p>
<ul style="list-style-type: none"> Non-genital acts 	<ul style="list-style-type: none"> Mark the appropriate box. If yes, describe the act and note where it occurred on the adjacent line. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. Note: Identify bites and alert law enforcement about their existence. Bites can provide very specific evidence and they fade very quickly. Bites should be swabbed for saliva, measured, and photographed. Contact a forensic odontologist or law enforcement to evaluate the need for impressions. Note: The term suction injury means "hickey."
<ul style="list-style-type: none"> Other act(s) 	<ul style="list-style-type: none"> If yes, describe.
<ul style="list-style-type: none"> Ejaculation 	<p>Mark the appropriate box. For body surfaces, note location(s) on the diagrams. For clothing, bedding, or other surface(s), describe in the space provided. If more than one perpetrator ejaculated, identify each one by number on the lines adjacent to the boxes. If "unsure" is checked, provide a description in the adjacent space.</p>
<ul style="list-style-type: none"> Lubricant products 	<p>Note whether a contraceptive, saliva, or a lubricant product was used. If yes, record the type or brand used, if known.</p>
<ul style="list-style-type: none"> Barriers 	<p>Mark the appropriate box. Indicate whether it was a condom, plastic bag, or other barrier.</p>
<ul style="list-style-type: none"> Force, threats, or weapons 	<p>If yes, describe.</p>
<ul style="list-style-type: none"> Strangulation (choking) 	<p>Mark the appropriate box, including the symptoms. <i>Note:</i> Strangulation occurs more often than previously thought.</p>
<ul style="list-style-type: none"> Pictures, videotapes, or social media 	<p>Mark the appropriate box. Photos, videos, or social media may be taken or shown.</p>
<ul style="list-style-type: none"> Drugs or alcohol 	<p>Ask about the possibility of forced, coerced, or suspected ingestion of alcohol or drugs. Mark the appropriate box. If yes:</p> <ul style="list-style-type: none"> For blood-alcohol analysis, collect 20cc or two 10cc of blood in a gray-stoppered evacuated blood collection vial up to 24 hours post-ingestion. For ingestion of drugs, collect 60cc or two 30cc of urine in a plastic or glass container. It is important to collect the first available sample. Some drugs may be detected in urine up to 96 hours after ingestion.
<ul style="list-style-type: none"> Loss of memory Lapse of consciousness 	<p>If the patient reports ingestion of drugs, describes symptoms, or shows signs of drug ingestion (e.g., lapse of consciousness, memory loss, abnormal vital signs, confusion), collect toxicology samples.</p>
<ul style="list-style-type: none"> Vomited after act(s) 	<p>If yes, describe. Vomiting can also be a possible indicator of drug or alcohol ingestion.</p>
<ul style="list-style-type: none"> Behavioral changes 	<p>If yes, describe.</p>

G. ACTS DESCRIBED BY PATIENT

Interview approach:

- Determine and use terms familiar to the patient.
- Allow the patient to describe the incident(s) to the extent possible.
- Follow-up questions may be necessary to ensure that all items are covered.
- Avoid asking questions that may be leading or suggestive.
- Gather as much information as possible from law enforcement officers and social workers to avoid redundant interviewing.

1. Record the acts disclosed by the patient and to whom.

Each act may lead to evidence of a chargeable crime. Any penetration, however slight, of a genital or anal opening by an object or body part constitutes an act. Oral copulation only requires contact.

- For yes answers, ask if there was associated pain or bleeding. Sometimes patients report no pain but say “tickled.”
- Use quotation marks to quote relevant statements. Example: “He puts his private in my pee pee.”
- Document if statement(s) made by the patient were spontaneous (i.e., not in response to a question or comment).
- Patient statements not heard directly by the recorder may be included (e.g., the child told the teacher that “he put his private in my pee pee”).
- Under non-genital acts, the term suction injury means “hickey.”
- Saliva or lubricant: If lubricant used, describe by name, color, odor, flavor, and container description (if known or disclosed).
- Condom or other forms of covering: Describe type or brand used (if known)
- If the patient experienced a lapse of consciousness, collection of toxicology samples as specified by local policy may be indicated.

2. Describe pain and/or bleeding (using patient’s exact words) and any additional pertinent history.

H. GENERAL PHYSICAL EXAMINATION: Collect and preserve evidence. Record findings.

1. Record vital signs, height, weight, percentiles, and BMI.
2. Record who is with child during examination or indicate N/A.
3. For females, record Sexual Maturity Rating/Female Tanner Stage – Breast

Sexual Maturity Rating/Female Tanner Stages – Breast	Genital Tanner Stages
1. Preadolescent 2. Breast and papilla elevated as small mound; areola diameter increased 3. Breast and areola enlarged; no contour separation 4. Areola and papilla form secondary mound 5. Mature; nipple projections, areola part of general breast contour	1. No or fine vellus (peach fuzz) hair 2. Sparse; long, straight, pigmented hair 3. Increased density; dark coarse curly hair 4. Abundant hair; sparing medial thighs 5. Abundant hair; spreading to medial thigh

4. Describe the patient's general physical appearance.
5. Describe the patient's general demeanor.
 - Describe behaviors such as crying, fearfulness, willingness or ability to cooperate, responsiveness, ability to give history, etc. Avoid the use of vague, subjective, or judgmental descriptors. Documenting helps the examiner recall the patient's behavior and response during the examination for future reference. The issue of non-cooperativeness is relevant because it can cause exam delays and impair the examiner's ability to collect evidence.
6. Record any relevant statements made during the exam and use quotation marks for direct quotes. Use addendum if needed.
7. Describe the condition of clothing upon arrival (e.g., rips, tears, presence of foreign materials). Collect outer and under clothing worn during or immediately after the incident. Record whether clothing was brought in for the exam.
 - Wear gloves while collecting clothing.
 - Have the patient disrobe on two sheets of paper placed one on top of the other on the floor. Have the patient remove his or her shoes before stepping on the paper. The shoes may be collected, if indicated, and packaged separately.
 - Package each garment in an individual paper bag, label, and seal.
 - Carefully fold the top sheet of paper into a bundle, label, and seal. Discard the bottom sheet. Place this large bundle and all individually bagged garments into a large paper bag(s) with a chain of custody form, label, and seal.
 - Wet stains or other wet evidence require special handling. Consult local policy.
 - Give special focus to items that are close to the genital structures or otherwise have the highest potential to contain seminal fluid according to the assault history
8. Conduct a physical examination. Record all findings and whether the general exam was within normal limits.
 - Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, and burns. Note areas of tenderness or induration.

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials (e.g., grass, sand, stains, dried or moist secretions, or positive fluorescence). If none of the above are present, mark "No Findings."

Documentation of Injuries and Findings Using Diagrams and Legend

- Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system.
- Bruises: Describe shape, size, and color.
- Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. Example: A-1, EC 2x3cm red/purple indicates that the first finding on Diagram A is an ecchymosis (bruise) that is red/purple in color and 2x3 centimeters in size. See example below.

Locator #	Type	Description
A-1	EC	2x3cm red/purple
A-2	DS	Dried secretion
A-3	CS	Control Swab

- Photograph injuries and other findings using a digital camera with a macro lens or colposcope with camera attachment.
 - Use proper forensic photographic techniques.
 - Use an appropriate light source and a scale near the finding.
 - Note: The plane of the film must be parallel to the plane of the finding.
9. Scan the entire body with an Alternate Light Source (ALS) preferentially 450nm. Note fluorescent area(s) on the diagrams and record in legend as ALS⊕.
 - Swab moist secretions with a dry swab to avoid dilution. Label and air dry before packaging.
 - Swab dried stains and/or ALS positive area(s) with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Indicate ALS⊕ on body diagrams.
 - Collect foreign materials such as fibers, sand, hair grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - Record all findings on the diagrams and the legend as shown above.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites.
 10. Collect dried and moist secretions, stains (including semen, bloodstains, saliva from bites, suction injury [hickey], licking, and kissing), and foreign materials from the body.
 11. Collect fingernail swabbings using 2 microtipped swabs per hand.
 - Use 2 microtipped swabs per hand to swab under the fingernails. Place swabs from each hand into separate envelopes. Label (indicating right or left hand) and seal. Do not cut the fingernails.
 12. Collect 2 swabs from right breast/nipple and 2 swabs from left breast/nipple. Consider swabs from umbilicus and each side of inner thigh.

I. HEAD, NECK, AND ORAL EXAMINATION

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials.

- Give special focus to the lips, perioral region, and nares in the examination.
- Record injuries and other findings using the diagrams and legend.
- Photograph injuries and other findings using a digital camera with a macro lens or a colposcope with a camera attachment.

2. Scan the entire body with an Alternate Light Source (ALS) preferentially 450nm. Note fluorescent area(s) on the diagrams and record in legend as ALS⊕.

- Swab moist secretions with a dry swab to avoid dilution. Label and air dry before packaging.
- Swab dried stains and/or ALS positive area(s) with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Indicate ALS⊕ on body diagrams.
- Collect foreign materials such as fibers, sand, hair grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
- Record all findings on the diagrams and the legend as shown above.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites.

3. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck.

4. Examine the oral cavity for injury and foreign materials.

- Give special focus to frenulums, buccal surfaces, gums, and soft palate.
- Record injuries, foreign materials, and other findings using the diagrams and legend.
- Photograph injuries and other findings using a digital camera with a macro lens or colposcope with camera attachment.
- Collect foreign materials found in the oral cavity, e.g., hair. Package, label, and seal.

5. Collect 2 swabs from the oral cavity for seminal fluid up to 24 hours post-assault. Separately swab the perioral area with 2 swabs up to 24 hours post-assault.

- Swab the gum to the tonsillar fossae, the upper first and second molars, behind the incisors, and the fold of the cheek (buccal space).
- Label and air dry the swabs. Package, label, and seal.

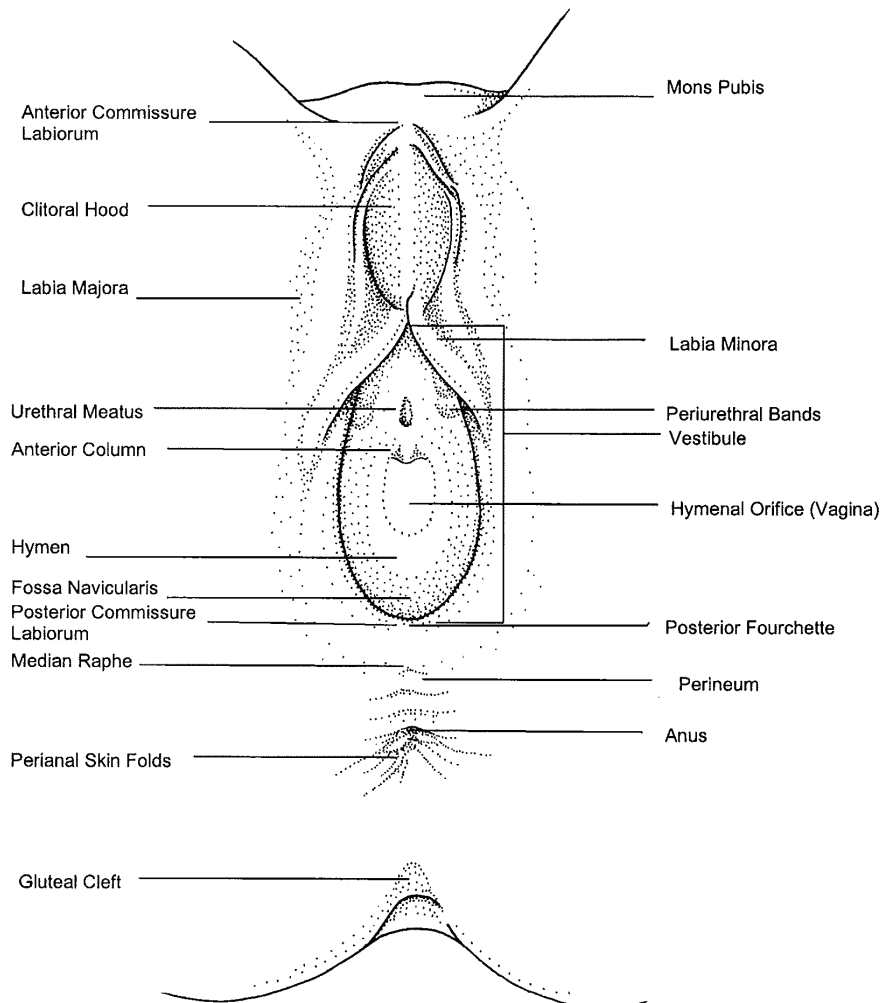
6. Collect 2 swabs from the right side of neck and 2 swabs from the left side.

7. Collect head hair reference samples according to local policy, only if a foreign hair is found.

- Head hair reference samples can also be collected at a later date. If collected, cut the hairs *close to the skin*, or pull (or have patient pull) 20–30 hairs representative of variations in length and color from different areas of the head. Package, label, and seal.

FEMALE GENITALIA WITH LABELS: SUPINE VIEW

Diagrams of female and male genitalia with definitions are provided in Appendix N of the Protocol



J. GENITAL EXAMINATION — FEMALES

Advisory: Record observations, take photographs, and collect swabs before using the visualization enhancement Toluidine Blue Dye.

1. **Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings.**
 - Use digital camera with a macro lens or a colposcope to photograph injuries and other findings.
 - Record size and appearance of injuries, foreign materials, and other findings using the diagrams, the legend, and a consecutive numbering system. Note swelling and areas of tenderness and induration. Describe genital findings as the face of a clock with the top of a genital diagram being 12:00 and the bottom of a genital diagram being 6:00
2. **Record examination methods and position(s).**
 - Use **knee-chest** position for prepubertal children
 - **Prone:** Child rests on knees with upper chest on the examination table in a lordotic (swayback) posture.
 - **Supine:** Child rests on back with flexed knees brought to chest.
 - **Record examination techniques and whether separation and traction methods were used.**
 - **Separation:** Labia majora are gently separated in a lateral and downward direction exposing the structures within the vestibule.
 - **Traction:** Labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner.
 - **Moistened swab:** Used to reposition hymenal tissue. **Always use a moistened swab to reduce discomfort.**
 - **Saline/water:** Used to float/separate the hymenal tissue that may be rolled or overlapping upon itself.
 - **Speculum exams: Never use a speculum with prepubertal females.**
 - **Collect swabs before using the visualization enhancement Toluidine Blue Dye.**
3. **Record Sexual Maturity Rating/Genital Tanner Stage by checking the appropriate box.** Descriptions are provided on page 5.
4. **Examine the genital structures. Check the ABN box(es) if there are abuse/assault-related findings.**
 - **Use Diagram G or H that best illustrates your findings.**
 - **Record morphology of the hymen:**
 - **Annular:** Circumferential.
 - **Crescentic:** Attachments at about the 11:00 and 1:00 positions without tissue being present between the two attachments.
 - **Imperforate:** No opening.
 - **Septate:** Bisected by a band of hymenal tissue creating two or more orifices.
 - **Terms relating to the hymen:**
 - **Estrogenized:** Influenced by estrogen; hymen takes on a thickened, redundant, pale appearance.
 - **Fimbriate/denticular:** Multiple projections and indentations along edge.
 - **Narrow/wide rim:** Viewed in the coronal plane—from edge of hymen to muscular portion (attachment) of the vaginal opening.
 - **Membrane thickness:** Relative amount of tissue between internal and external surfaces of the hymenal membrane.
5. **Scan the entire body with an Alternate Light Source (ALS) preferentially 450nm. Note fluorescent area(s) on the diagrams and record in legend as ALS⊕.**
 - **Collect dried and moist secretions, stains, foreign materials, and foreign bodies.**
 - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
 - **Swab dried stains and/or ALS positive area(s)** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Indicate ALS⊕ on body diagrams.
 - **Collect foreign materials** such as fibers, sand, hair grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - Allow foreign bodies to air dry for at least one hour. If any item is still wet, package and label as “wet evidence.” Consult local policy.
 - **Cut matted pubic hairs bearing crusted material** and place in a bindle. Package, label, and seal.
 - **Record all findings** on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites.

Swab collection: Collection of intra-vaginal swabs is rarely done on prepubertal girls. If the hymenal diameter is not large enough to insert a swab without touching the edge of the hymen, then vaginal swabbing should NOT be done. If vaginal swabs are not collected, vulvar and vestibular swabs must be collected in all cases.

6. **Collect swabs.**
 - **Swab mons pubis area for all patients using 2 swabs.**
 - **Prepubertal female(s): collect 2 vulvar and 2 vestibular swabs**
 - Hold the swabs together as a unit, rotate them as a unit to ensure uniform sampling. Allow adequate time for saturation of the swabs.
 - **Pubertal female(s): collect 4 vaginal swabs (ideally) from the vaginal pool**
 - Hold the swabs together as a unit and insert them into the vaginal pool at the same time. Rotate the swabs as a unit in the vaginal vault to ensure uniform sampling. Allow for adequate time for saturation of the swabs. Separate the swabs before drying.
 - **Pubertal female(s): consider collecting 2 cervical swabs only if a speculum can be used without causing trauma**
 - Label the swabs so it is clear that these are cervical, not vaginal swabs. Air dry, package, label, and seal.
7. **Collect pubic hair brushing, if applicable. Use the small soft brush in the evidence kit.**
 - Place a paper sheet under the patient's buttocks. Brush the pubic hair downward to remove any loose hairs or foreign materials. Collect and fold the paper with the brush inside. Package, label, and seal.
8. **Collect public hair reference samples only if a foreign hair is found.**
 - Consult local the local crime laboratory policy to determine whether to cut the hairs *close to the skin* or pull (or have the patient pull) 20–30 hairs representative of variations in length and color from different areas of the pubic region. Reference samples can also be collected at a later date.

K. GENITAL EXAMINATION – MALES

Advisory: Record observations, take photographs, and collect swabs before using the visualization enhancement Toluidine Blue Dye.

1. **Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings.**
 - Use a digital camera with a macro lens or a colposcope to photograph injuries and other findings.
 - Record size and appearance of injuries, foreign materials, and other findings using the diagrams, the legend, and a consecutive numbering system. Note swelling and areas of tenderness and induration. Describe genital findings as the face of a clock with the top of a genital diagram being 12:00 and the bottom of a genital diagram being 6:00.
 - **Record examination position and examination techniques used.**
2. **Record Sexual Maturity Rating/Genital Tanner Stage by checking the appropriate box.** Descriptions are provided on page 5.
3. **Record whether circumcised or not.**
4. **Scan the entire body with an Alternate Light Source (ALS) preferentially 450nm. Note fluorescent area(s) on the diagrams and record in legend as ALS⊕.**
 - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
 - **Swab dried stains and/or ALS positive area(s)** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Indicate ALS⊕ on body diagrams or bindles, then place into envelopes.
 - **Collect** foreign materials such as fibers, sand, hair grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - **Cut** matted pubic hairs bearing crusted material and place in a bindle. Package, label, and seal.
 - **Record** all findings on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites.
5. **Collect dried and moist secretions, stains, and foreign materials.**
6. **Check the ABN box(es) if there are abuse/assault-related findings.**
7. **Collect pubic hair using small soft brush in the evidence kit, if applicable.**
 - Place a paper sheet under the patient's buttocks. Brush the pubic hair downward to remove any loose hairs or foreign materials. Collect and fold the paper with the brush inside. Package, label, and seal.
 - Only collect pubic hair reference samples if a foreign hair is found.
 - Consult local crime laboratory policy to determine whether to cut the hairs *close to the skin* or pull (or have the patient pull) 20–30 hairs representative of variations in length and color from different areas of the pubic region. Reference samples can also be collected at a later time.
8. **Collect 2 penile swabs including glans and shaft.**
 - Hold the swabs together as a unit and swab the glans, shaft, and base of the penis with a rotating motion to ensure uniform sampling. Avoid swabbing the urethral meatus. Use swabs moistened with sterile, deionized, or distilled water for these swabbings. Air dry, package, label, and seal.
9. **Collect 2 scrotal swabs.**
 - Hold the swabs together as a unit and swab the scrotum in a rotating motion, focusing on the area that is in closest proximity to the penis. Use swabs moistened with sterile, deionized, or distilled water. Air dry, package, label, and seal.

L. FEMALE/MALE PERIANAL/ANAL EXAMINATION

1. **Examine the buttocks, perianal skin, and the anal folds for injury, foreign materials, and other findings.**
 - Use a digital camera with a macro lens or colposcope to photograph injuries and other findings.
 - Record examination positions, methods, and techniques used.
 - Use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.
 - Indicate if anal dilation is immediate or delayed. If anus dilates, record if stool is present in the rectal ampulla.
2. **Scan the entire body with an Alternate Light Source (ALS) preferentially 450nm. Note fluorescent area(s) on the diagrams and record in legend as ALS⊕.**
 - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
 - **Swab dried stains and/or ALS positive area(s)** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Indicate ALS⊕ on body diagrams or bindles, then place into envelopes.
 - **Collect foreign materials** such as fibers, sand, hair grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - **Record all findings** on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites.
3. **Collect dried and moist secretions, stains, foreign materials. Foreign materials may include lubricants.**
4. **Check the ABN box(es) if there are abuse/assault-related findings. Record findings using the legend and diagrams.**
 - Indicate whether there is anal dilation (immediate or delayed).
 - Indicate where stool is present in the rectal ampulla.
5. **Collect 2 perianal swabs.**
 - Label and air dry the swabs. Package, label, and seal.
6. **If anal injury is suspected or if there is any sign of anal bleeding and/or anal discharge, use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.**
 - Check the box if there is anal bleeding and/or anal discharge. Describe findings.
 - If an anosopic examination is medically indicated, document under examination methods. Sedation or anesthesia is recommended for the prepubertal child.
7. **Use space for additional information.**

All swabs must be air dried prior to packaging (Pen. Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Only place samples from one patient at a time in a swab drying box. Wipe or spray the swab drying box with 10% bleach before each use.

Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, signature or initials of the person who collected the evidence. Include the legend locator number, if the legend was used to document the location from which the evidence was collected. Package containers in a Sexual Assault Forensic Evidence (SAFE) Collection Kit and record the chain of custody.

M. RECORD ALL EVIDENCE COLLECTED AND SUBMITTED TO THE CRIME LABORATORY

1. Record all items of clothing collected. Indicate whether clothing was brought to the exam.
2. Record all foreign materials collected and the name of the person who collected them. *Note:* An intravaginal foreign body may include a tampon, diaphragm, condom, etc. Consult the local crime laboratory for packaging recommendations for foreign bodies.
3. Record whether body surface and cavity evidence swabs were collected.
 - Record the number of swabs collected and the person who took the samples.

N. TOXICOLOGY SAMPLES

- Collect samples for blood-alcohol up to 24 hours and urine toxicology up to 120 hours at the discretion of the examiner and/or law enforcement officer in accordance with local policy.
- Cleanse the arm with a non-alcoholic solution and collect 20cc or two 10cc of blood in a gray-stoppered evacuated vial. Label vial and envelope, and seal.
- Up to 120 hours after suspected ingestion of drugs, collect a urine specimen of 60cc or two 30cc in a plastic or glass container. It is important to collect the first available sample.

O. DNA AND OTHER REFERENCE SAMPLES: If reference sample are collected at the time of the exam, ALWAYS collect after the evidence samples. Use a buccal swab for DNA reference samples.

- **Buccal (inner cheek) swabs:** Collect as a DNA sample. Rub 2 swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. (Dedicated buccal sampling systems may be used.) Air dry, package, label, and seal.
- **Head hair:** Only if a foreign hair is found, cut the hair *close to the skin* or pull (or have patient pull) 20–30 hairs representative of variations. Package, label, and seal. Hair reference samples can also be collected at a later time.
- **Pubic hair from pubertal males and females:** Only if a foreign hair is found, *cut the hair close to the skin*, or pull (or have patient pull) 20–30 hairs representative of variations. Package, label, and seal.

P. PHOTO DOCUMENTATION METHODS

- Document photographic methods used, and whether still or video images were taken. Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings.

Q. FINDINGS AND INTERPRETATIONS

1. Check appropriate box to summarize findings.
 - Findings and interpretations are based on both the patient history available at the time and the medical examination.
 - Check if lab results or photo review are pending.
 - Record additional comments regarding findings, interpretations, and recommendations; or, use to describe variations of normal congenital abnormalities.
2. Check the box to describe your interpretation of the findings.
3. Local exam team policy may include formal review of the photographic record and this form, and/or a follow up exam. Check the box if this is applicable or not applicable.

Note: Examinary clinician reserves the right to amend or revise final interpretation pending further consultation, _____

R. RECORD LAB TESTS PERFORMED

- Consider abuse history, patient's medical history, and exam findings to determine tests needed.
- Pregnancy testing should be considered for all females Sexual Maturity Rating/Tanner Stage 3 and above, irrespective of menarche.
- Additional tests performed depend upon clinical assessment (e.g., urinalysis, biopsy, cultures, viral titers).

S. PRINT NAMES OF PERSONNEL INVOLVED. OBTAIN SIGNATURE AND LICENSE NUMBER OF EXAMINER.

T. EVIDENCE DISTRIBUTION: List to whom the evidence was given.

U. OBTAIN SIGNATURE OF OFFICER RECEIVING EVIDENCE.